MHS Reengineering Coordination

MHS Optimization Plan

The MHS is responsive and accountable to DOD, line leadership, and our beneficiaries to ensure force health protection and optimize the health of MHS beneficiaries by providing best value health services using best clinical and business practices.

CHARTER

The MHS' success depends on innovations and enterprise-wide reengineering. The Reengineering Coordination Team is chartered by and reports to MHS leadership to conduct research, coordinate working groups, integrate initiatives, and recommend strategies and operational plans to achieve the MHS vision.

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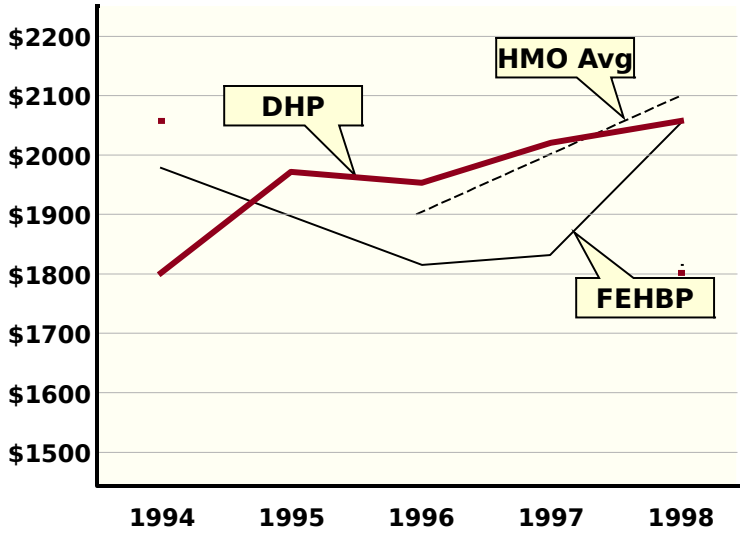
Comments in CNA Report
Germane to MHS Reengineering

- Some UM savings are achievable
- Effect of prior DHP budget cuts
  - No change in MTF access
  - Shift 65+ care to civilian sector
  - ∀ ↓ Equipment & property maintenance
- **How can UM wedge be achieved?**
  - "Cut staff": affects readiness mission
  - Cut costs with current staffing:
    - Consumable savings
    - "Best bet—recapture CHAMPUS workload and earn the *full* cost of care—much more lucrative"
- **Conclusions:**
  - Savings must be from CHAMPUS recapture
  - MTFs must have appropriate specialty mix

Comparison of Per User Costs



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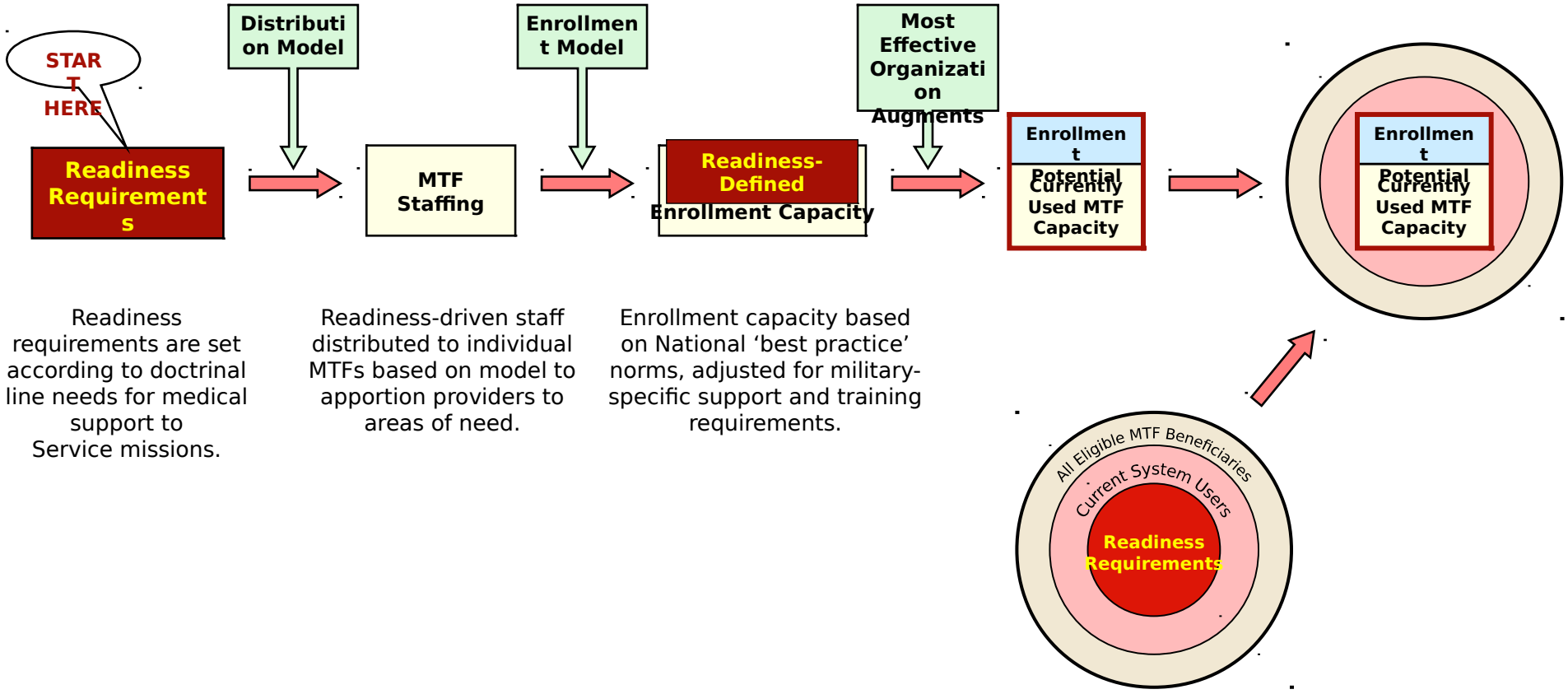
Readiness-Based Resource Improvement Model

Translating Readiness Requirements into Enrollment Capacity



Readiness requirements are set according to doctrinal line needs for medical support to Service missions.

Readiness-driven staff distributed to individual MTFs based on model to apportion providers to areas of need.

Enrollment capacity based on National 'best practice' norms, adjusted for military-specific support and training requirements.

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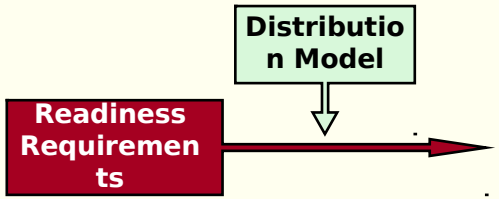
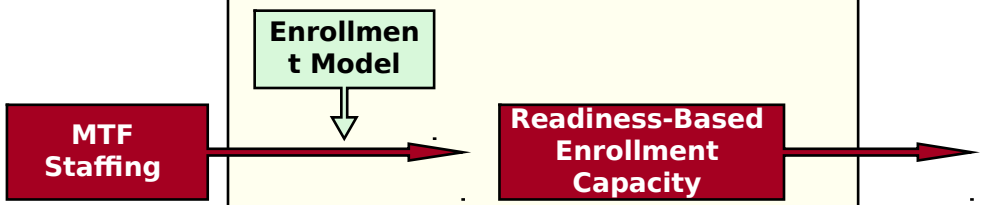
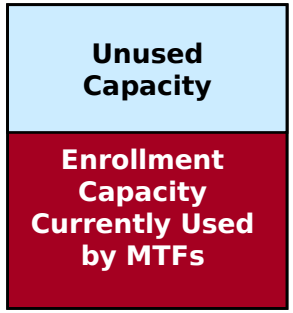
Critical MHS Reengineering Components

TRISERVICE READINESS MODEL
Determine ideal standardized model for personnel readiness requirements and how to distribute them in peacetime.



TRISERVICE ENROLLMENT MODEL
Use civilian 'best practice' enrollment models to determine the reasonable potential system capacity based on readiness driven staffing.





READINESS COSTING MODEL
Determine the "cost of readiness" so these costs can be subtracted from total DHP costs, yielding true costs for non-readiness service delivery portion of our mission.

POPULATION HEALTH IMPROVEMENT
Use "best clinical practices" and other initiatives to maximize productivity, quality, and consistency of MHS health service delivery. (MHS Initiative #4)

TRISERVICE WORKLOAD MODEL
Determine a uniform system which will allow all Services to accurately report and compare workload delivered in our MTFs and through the Managed Care Support Contracts.

TRISERVICE RESOURCING MODEL
Determine an allocation system which will allow all Services to apportion resources based on comparable processes and equivalent reporting

TRISERVICE METRICS
Determine the specific comparable metrics which will allow all Services to report progress toward MHS goals.

"MOST EFFECTIVE ORGANIZATION"
Determine the requirements of a "most effective" health services delivery system using best business practices and analyze how to best fill the gap to maximize

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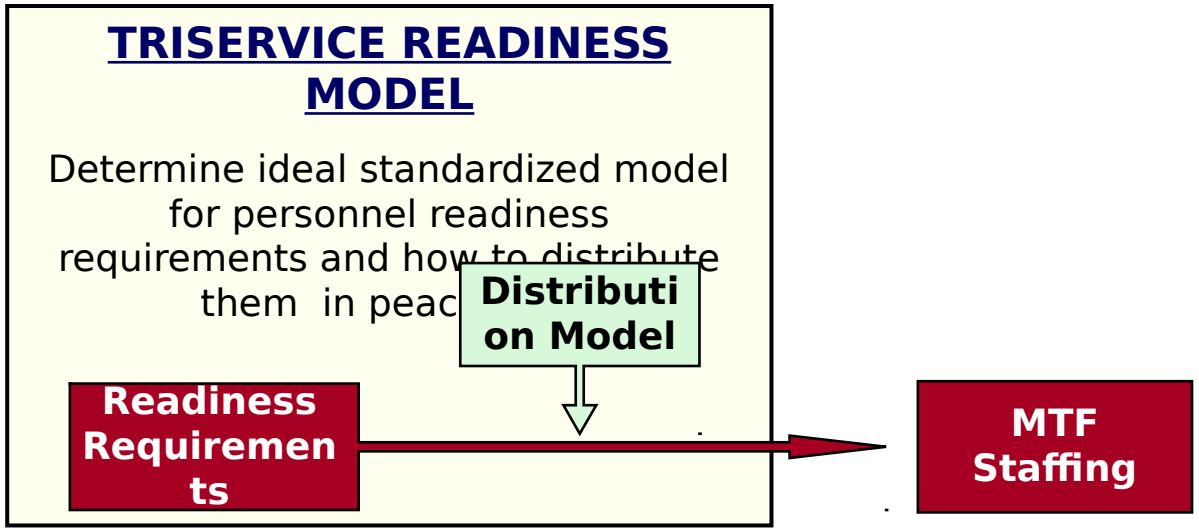
TRISERVICE READINESS MODEL
Determine ideal standardized model for personnel readiness requirements and how to distribute them in peac
Distributi on Model
Readiness Requiremen ts
MTF Staffing

- **Readiness mission is foundation of reengineering vision**
- **Triservice agreement on DOD Sizing Model**
  - *Readiness-based staffing*
  - *Baseline staffing to meet mandated line mission element support*
- **Staff distribution**
  - *Single distribution model based on Service and local requirements*
  - *Follows Service-specific garrison support mission, considering operational and MTF requirements, GME support, etc.*
- **Progress -** *Basic model complete (TORR: Total Operational Readiness Requirements)*

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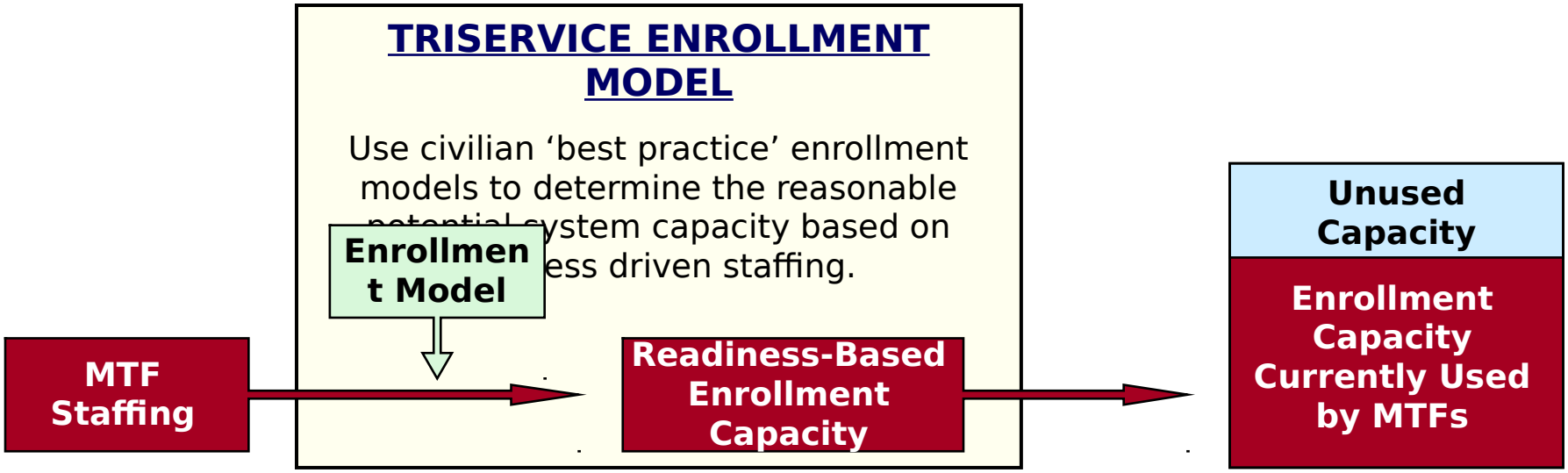
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Use civilian 'best practice' enrollment models to determine the reasonable
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Enrollmen t Model
MTF Staffing
Readiness-Based Enrollment Capacity
Unused Capacity
Enrollment Capacity Currently Used by MTFs

- **Triservice provider enrollment model**
  - *Based on best clinical and business practices used in successful civilian health service delivery systems*
  - *Adjusted for military-specific personnel and training requirements*
  - *Determine reasonable potential system capacities*
- **Must provide the right support for our providers** - *the "Most Effective Organization"*
- **Progress** - *Basic PCM model completed. Data being collected on Support Staff and Specialty Ratios and productivity. On schedule.*

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POPULATION HEALTH IMPROVEMENT

Use “best clinical practices” and other initiatives to maximize productivity, quality, and consistency of MHS health service delivery. (MHS Initiative #4)

- **Goal: fully optimize clinical outcomes across the MHS**
- **Operationalize a DOD Utilization Plan including these elements:**
  - *Education*
  - *Heath promotion/prevention*
  - *Primary care management*
  - *Demand management*
  - *Referral management*
  - *Case management*
  - *Clinical pathways/practice guidelines*
  - *Disease management*
  - *Discharge planning*
- **Shift from interventional (individual) to preventive (population-based) services**
- **Progress** - *Core elements of plan and MHS Pop Health Support Office concept developed. On schedule.*

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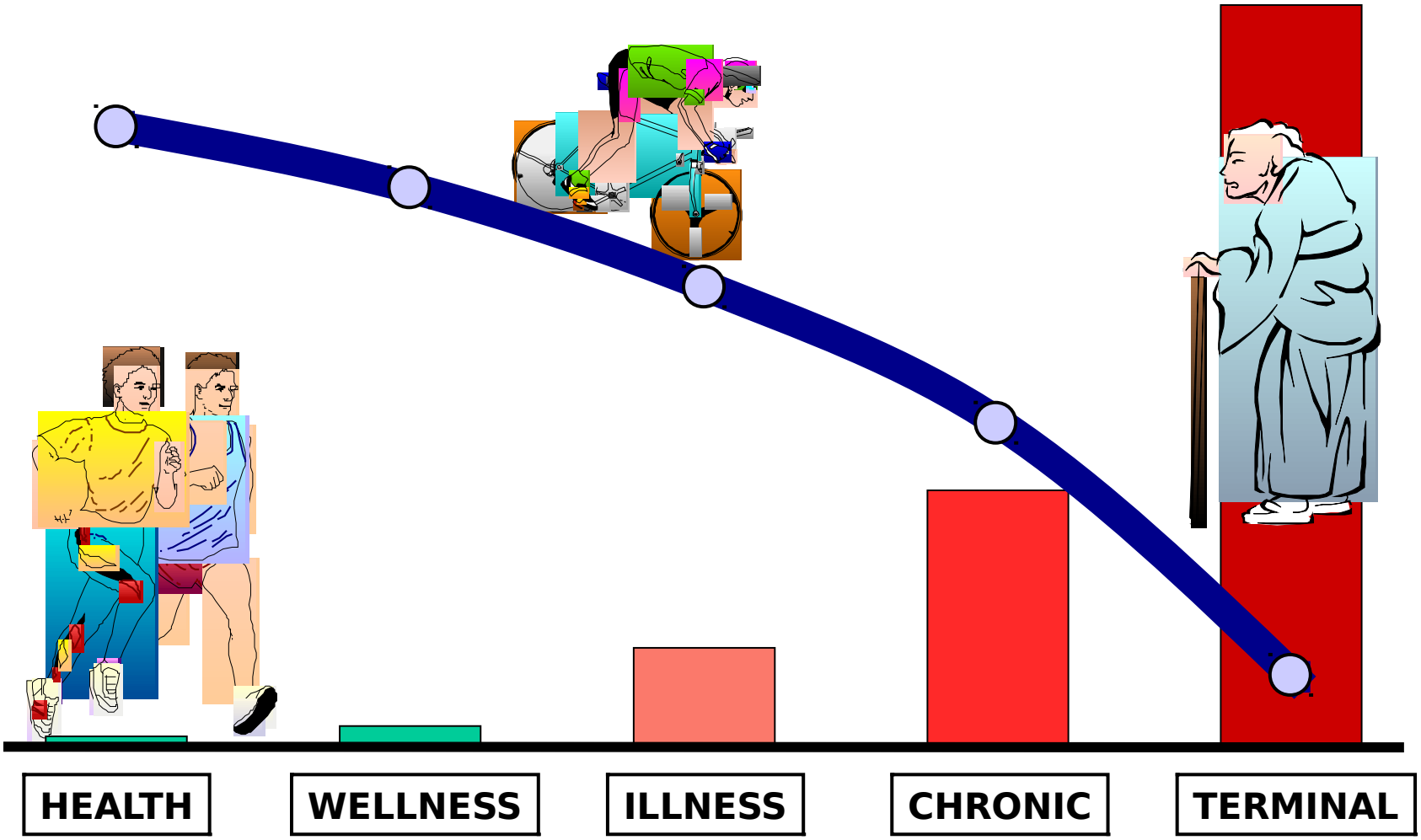
Cost Effectiveness of Health



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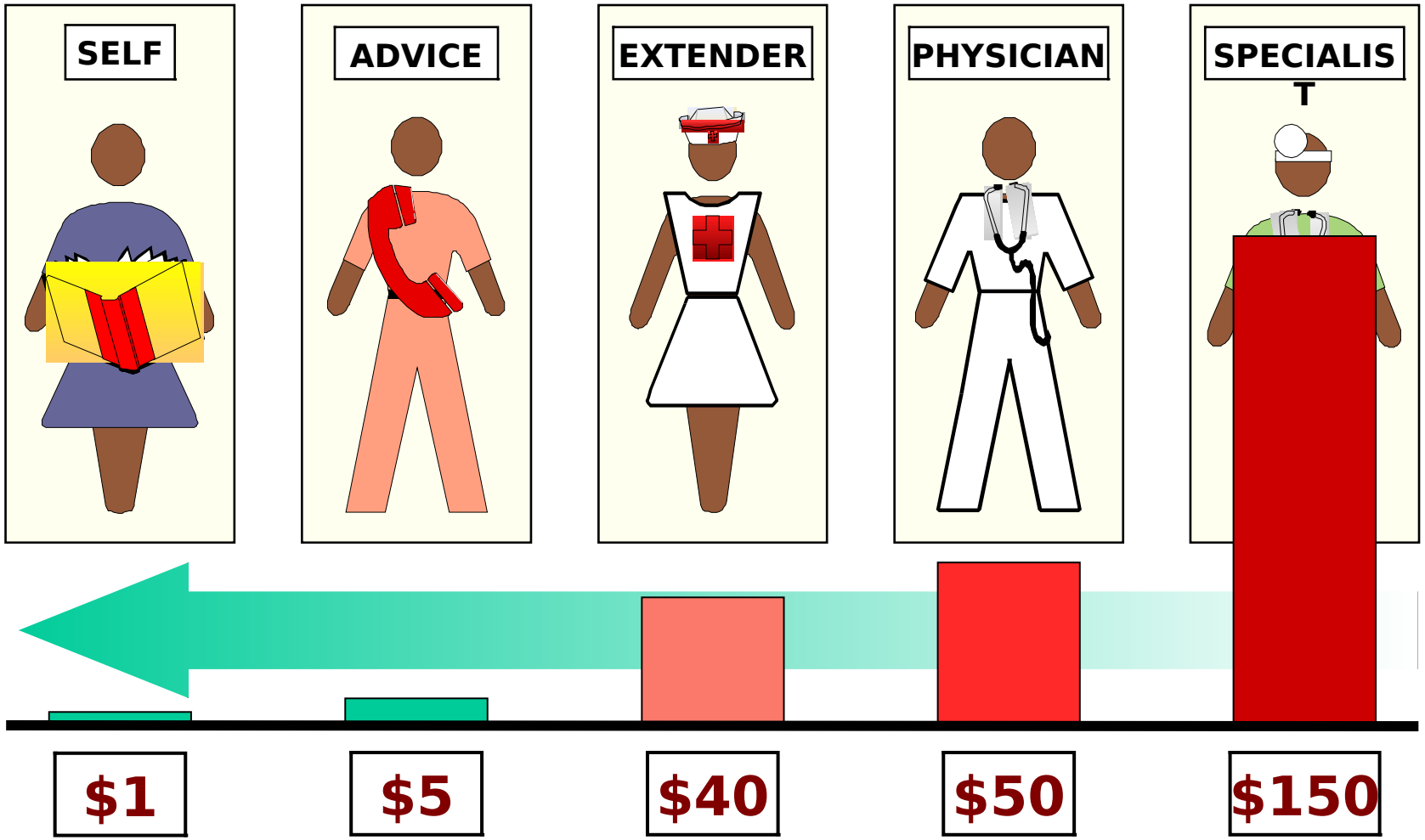
Cost Comparisons for Increasing Services



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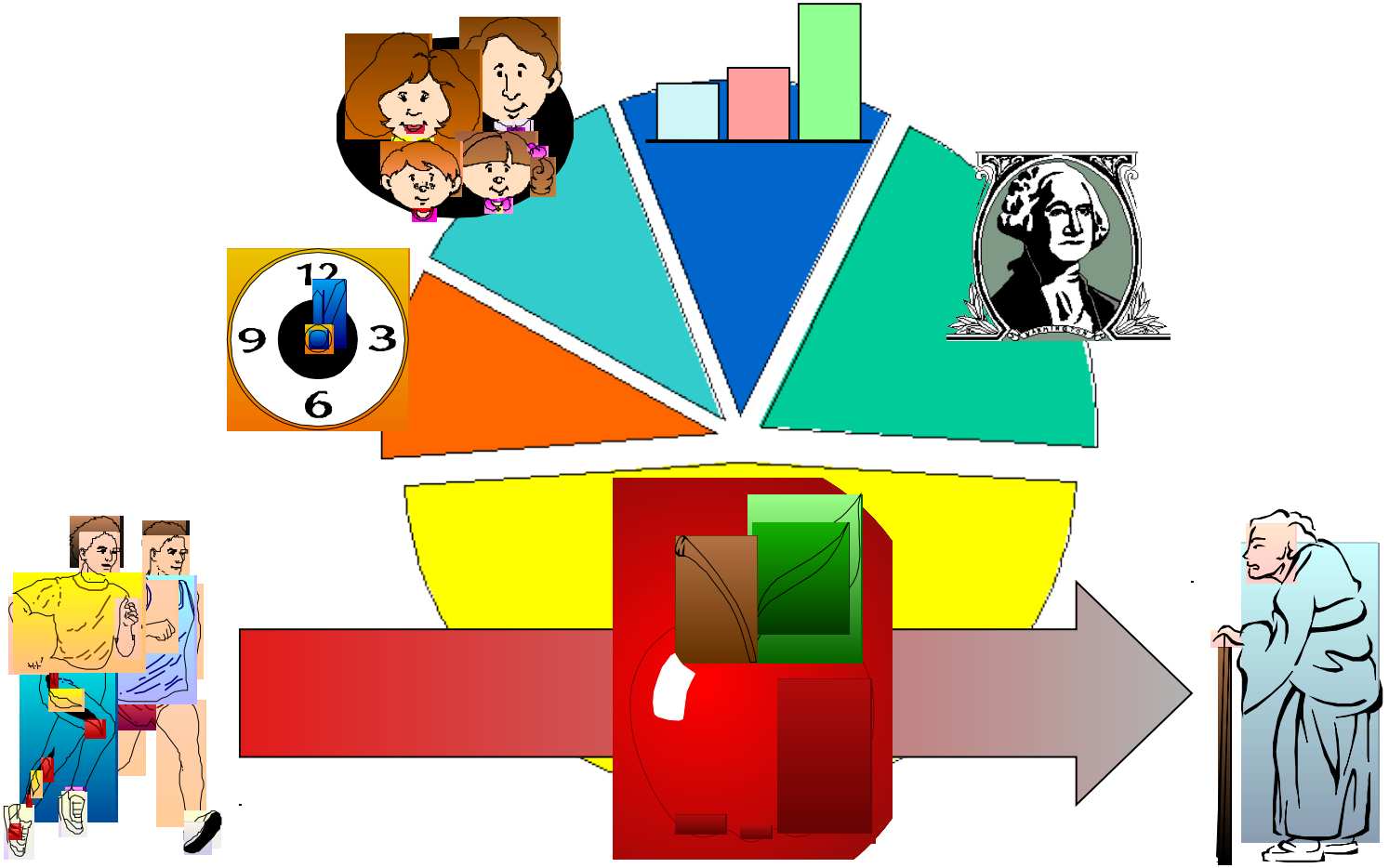
Our Valuable Resources



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TRISERVICE METRICS

Determine the specific comparable metrics which will allow all Services to report progress toward MHS goals.

- **Population-based**
- **Key to our ability to monitor progress**
- **Specific comparable metrics**
  - *Use existing data collected from MTFs and MCSCs*
  - *Applicable across MHS*
- **Will allow all Services to report progress toward MHS goals**
- **Web-based so MTF Commanders can monitor and provide feedback**
- **Progress -** *Working on HEDIS measures. Core Metrics completed. Developing proposal for near term provider support tool (Reg 3 Tool and PMT).*

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TRISERVICE WORKLOAD MODEL

Determine a uniform system which will allow all Services to accurately report and compare workload delivered in our MTFs and through the Managed Care Support Contracts.

- **Critical to our ability to draw interservice comparisons**
  - *A 'visit' in each Service should have precisely the same meaning*
  - *Currently widely disparate definitions*
- **Will determine a uniform system which will allow all Services to accurately report and compare workload delivered in our MTFs and through the Managed Care Support Contracts.**
- **Progress -** *Priorities and timelines established. Developing business rules and separating facility from provider resourcing. Working with CEIS and AF on ADS/CHCS metric. IPT established to address Medical Record Availability*

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TRISERVICE RESOURCING MODEL

Determine an allocation system which will allow all Services to apportion resources based on comparable processes and equivalent reporting methods.

- **Linked with and of equal importance to triservice workload accounting model**
- **Single resource allocation system**
  - *Will allow Services to apportion resources based on comparable requirements*
  - *Equivalent reporting methods for interservice comparisons*
  - *Full asset visibility*
- **Not a single accounting system**
- **Progress -** *RMs developing resourcing template employing enrollment factors to test in 6 sites in FY00.*

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READINESS COSTING MODEL

Determine the "cost of readiness" so these costs can be subtracted from total DHP costs, yielding true costs for non-readiness service delivery portion of our mission.

- **To demonstrating MHS cost effectiveness**
  - *Must clearly and accurately articulate military-specific costs*
  - *Must include all services not performed for other than active duty*
- **Total 'costs' are slightly higher than some competing programs (like FEHBP)**
  - *Must subtract cost of services not borne by our competitors*
  - *Deployments, personnel readiness, readiness training, etc.*
  - *Limited duty boards and others without civilian counterpart*
  - *Service-unique non-medical personnel requirements*
- **Remaining costs will reflect the true costs which can be compared with those of civilian benchmarks**
- **Progress -** *Complete. Military Unique Factor used in Enrollment Model.*

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“MOST EFFECTIVE ORGANIZATION”

Determine the requirements of a “most effective” health services delivery system using best business practices and analyze how to best fill the gap to maximize resource efficiency.

- **Must determine what additional resources are needed for the MHS to be a “most effective” health services delivery system**
- **Will analyze how to best fill the gap between the “most effective” model and the readiness-based staffing model**
  - *Examples: pathology, nutrition management, comptrollers*
  - *Not sufficient readiness-justified staffing*
  - *Required for health service delivery system to function optimally*
- **After gaps identified, must perform make/buy decisions -** *Business case analyses*
- **Progress -** *RCT engaged in FIWG process and establishing IM structure. Tricare 3.0 requirements aligned with plan. Appointment Standardization IPT established. Healthcare Reengineering will work with RCT to rapidly deploy field innovations. Will address optimal MHS processes, organization,*

Readiness-Based Resource Improvement Model

Translating Readiness Requirements into Enrollment Capacity

- **Readiness-based Service staffing model**
- **Augmented with staff required to be most effective health services delivery system**
- **Reasonable enrollment projections**
- **Population-based health will be paramount**
- **“Optimal” clinical practice guidelines will be adopted**
- **Workload will be accurately and uniformly accounted**
- **Readiness costs will be accurately determined**
- **Resources will be equitably apportioned**
- **Universal metrics will track system progress**

SHIFT FOCUS FROM INTERVENTION TO PREVENTION

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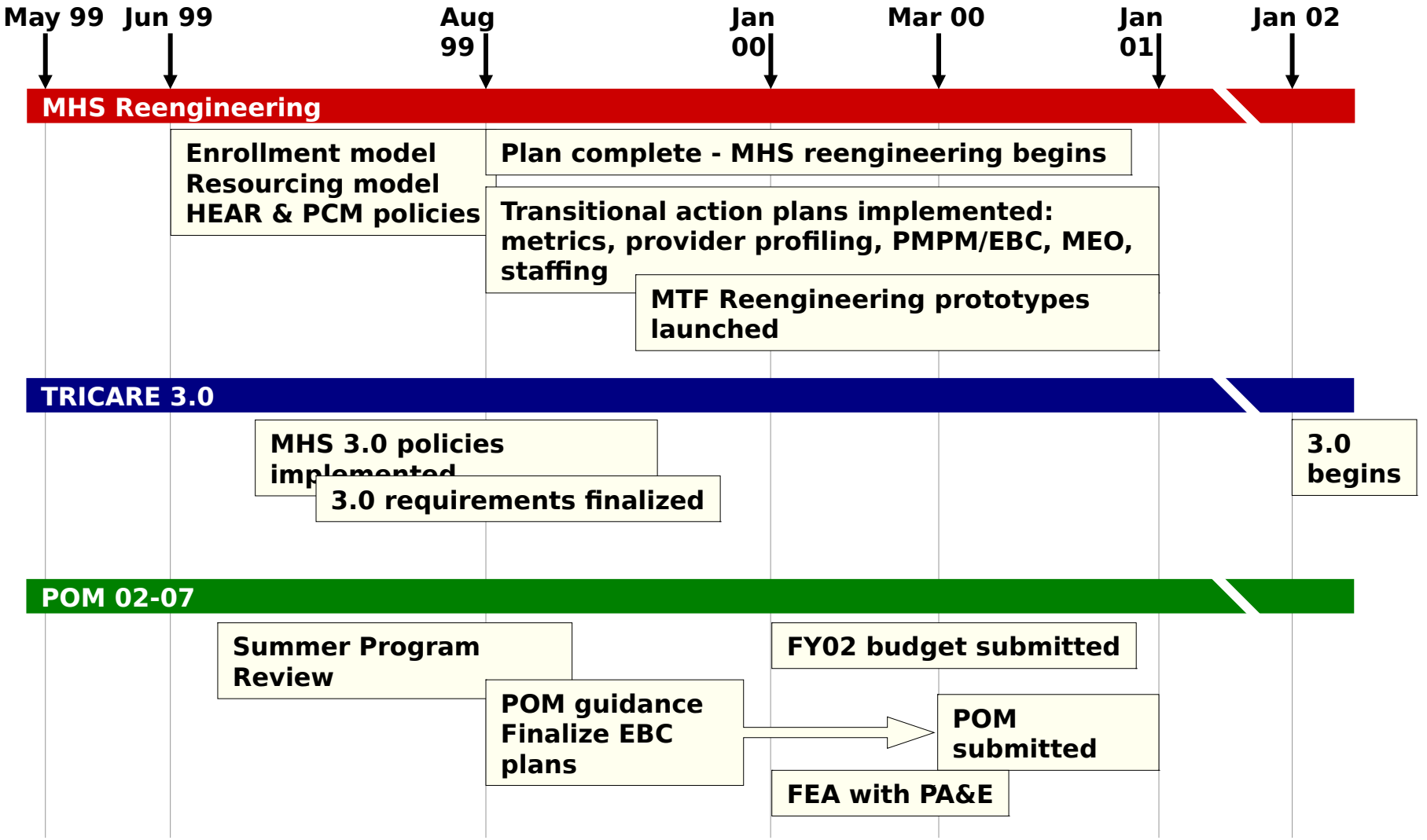
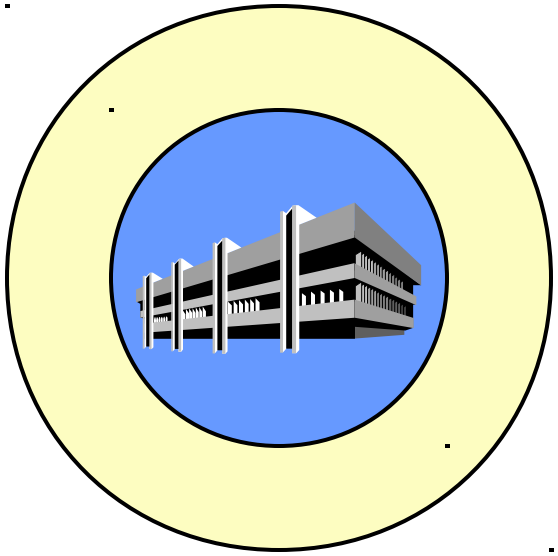


TRICARE 3.0 - The Bidding Process



1. MTFs estimate their enrollment potenti

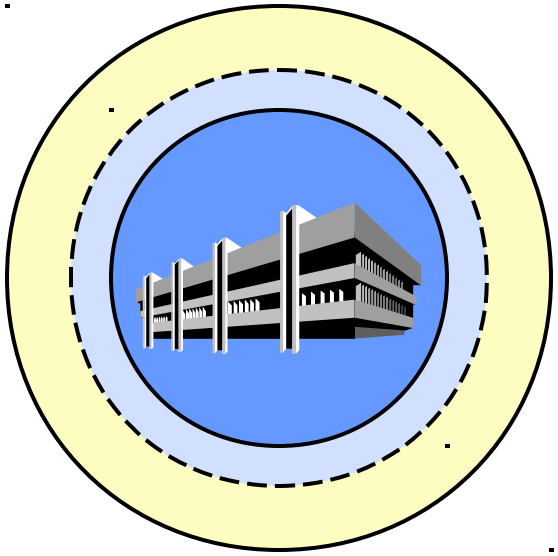
- How many beneficiaries can receive care in the MTF?
- **Requires an Enrollment Model**
  - *Nominal enrollment target (i.e.: 1500/PCP)*
  - *Modifiers to gain accuracy and identify opportuni*

2. Contractors bid on remaining workload

- Network size will depend on this estimate
- We will pay for this health care delivery and associated administrative costs

TRICARE 3.

TRICARE 3.0 - Workload Accounting



MTFs measure workload actually provided

- How does actual workload compare to predicted?
- **MORE workload performed by MTF…**
  - *On same number of beneficiaries?*
  - *On more beneficiaries?*
- **LESS workload performed by MTF…**
  - *Workload assumed to be provided by contractor!*

Requires accurate workload accounting!

- MEPRS and ADS
- Patient-level accounting
- Coding accuracy
- IM tools do not currently exist

TRICARE 3.

MHS Reengineering Coordination

Optimizing the MHS

Where We Are

- **Sub optimal access**
  - *Triage*
  - *Advice*
  - *Appointing*
- **Increased utilization**
  - *7 visits PMPY*
  - *Increased ED visits*
- **Lack of continuity**
- **Decreased "health status"**
- **Sub optimal satisfaction**

Where We Want to Be

- **Increase appropriate access**
- **Improve health**
  - *Enroll and assess*
  - *Prevention*
  - *Demand management*
  - *Referral management*
  - *Clinical practice guidelines*
  - *Case management*
- **Continuity**
- **Increased satisfaction & loyalty**

Obstacles to Provider Efficiency

- ☑ **Tools to know patient baseline status**
- ☑ **Prevention/tracking tool**
- ☑ **Effective demand management process**
- ☑ **Clinical information on patient and panel**
- ☑ **Clinical practice guidelines**
- ☑ **Clinical & admin support personnel & management**
- ☑ **Medical record availability**
- ☑ **Feedback on performance**

- ☒ **NOT A PROBLEM: desire to deliver quality care**

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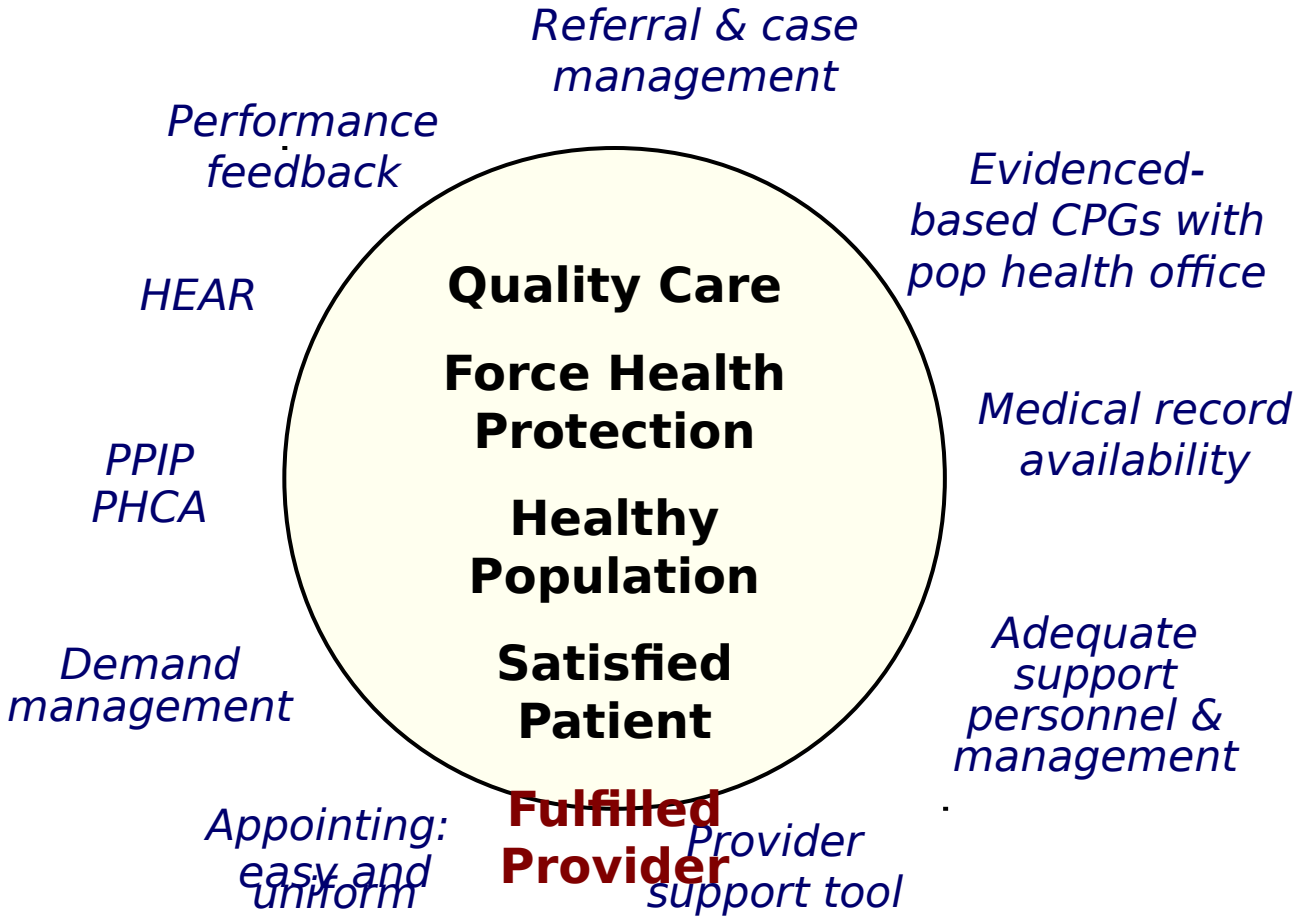
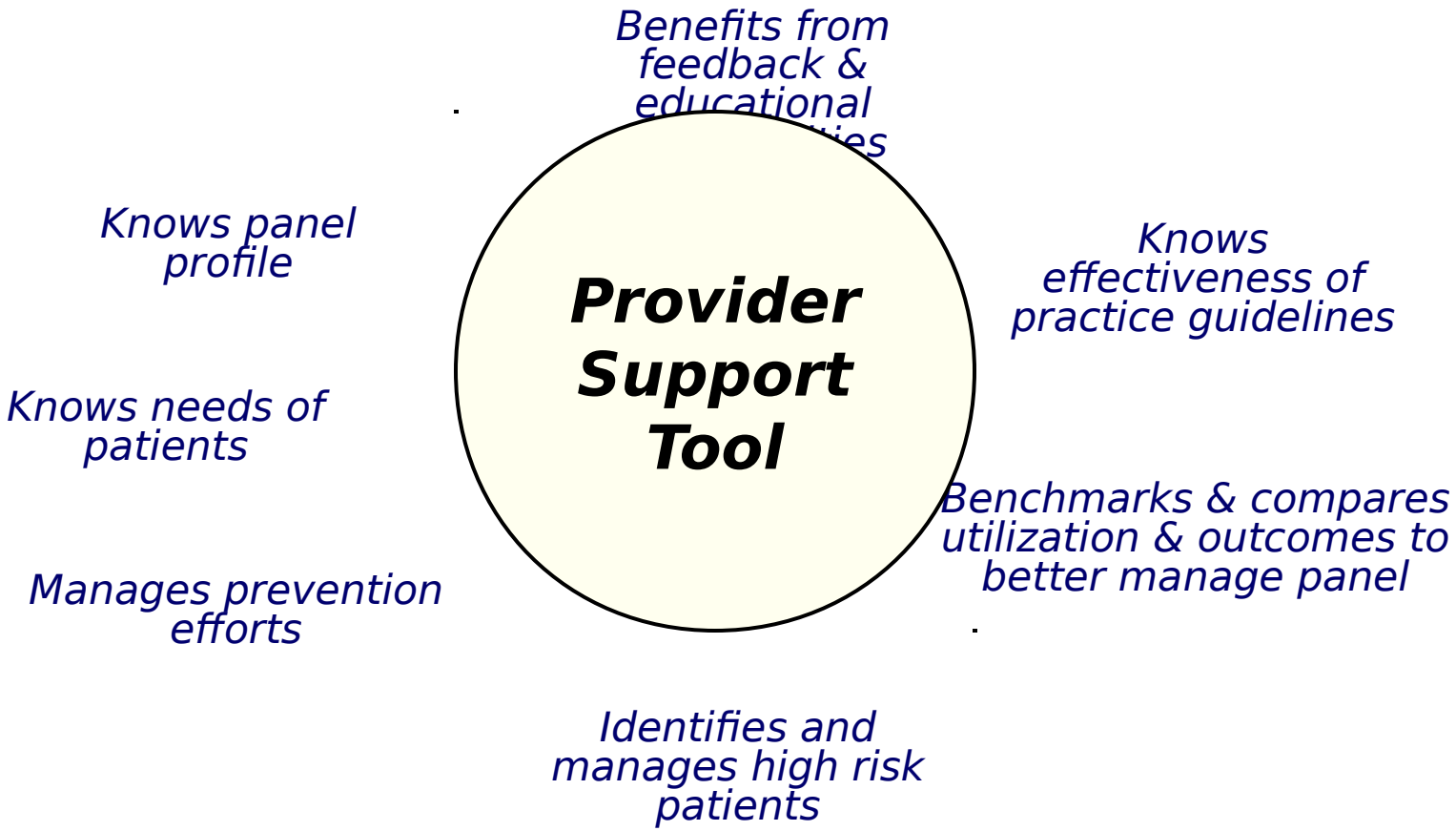
Provider Perspective



Provider Support Tool

Enabling PCMs to deliver population health


Benefits from feedback & educational
Knows panel profile
Knows effectiveness of practice guidelines
Provider Support Tool
Knows needs of patients
Benchmarks & compares utilization & outcomes to better manage panel
Manages prevention efforts
Identifies and manages high risk patients